**U.S. Department of Labor**

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

**Issue Date: 19 December 2005**

**IN THE MATTER OF:**

JAMES E. FREEMAN,
Claimant,

**v.** Case No.: 2004-BLA-06804

SHOSHONE COAL CORPORATION,
Employer,

**and**

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

**APPEARANCES:** Jay Michael Miller, Esq.
For the Claimant

Scott White, Esq.
For the Employer

**BEFORE:** Thomas M. Burke
Associate Chief Administrative Law Judge

## DECISION AND ORDER DENYING LIVING MINER'S BENEFITS

This case arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725 (2004). A hearing was held in McAlester, Oklahoma on April 14, 2005. The decision in this matter is based upon the testimony of Claimant at the hearing, all documentary evidence admitted into the record at the hearing, and the post-hearing arguments of the parties. The documentary evidence admitted at the hearing includes *Director's Exhibits* (*Dx.*) 1-54 and *Employer's Exhibits (Ex.)* 1-15.

### *Overview of the Black Lung Benefits Program*

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

### *Procedural History*

1. The miner filed a claim for benefits on June 11, 2001. *Dx.* 2.

2. A *Certificate of Marriage* establishes that Claimant married Helen Sue on September 28, 1975. *Dx.* 10.

3. On July 12, 2004, the district director issued a *Proposed Decision and Order* awarding benefits. *Dx.* 44. The district director based the award of benefits, in predominant part, on a finding that Dr. Odgers diagnosed chronic obstructive pulmonary disease due to smoking *and* coal dust exposure.

4. By letter dated August 18, 2004, Employer requested a hearing. *Dx.* 48.

5. The claim was referred to this Office for adjudication on September 16, 2004. *Dx.* 52.

### *Issues Presented for Adjudication and Stipulations*

The issues listed as contested on the CM-1025 include: (1) whether the miner suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) whether he is totally disabled; and (4) whether the miner's total disability was due to pneumoconiosis. *Dx.* 52.

At the hearing, Employer stipulated to 19 years of coal mine employment. *Hearing Transcript (Tr.)* at 5-6.

### *The Standard for Entitlement*

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718 (2004).[1] Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis; (2)

[1] As the miner last engaged in coal mine employment in the State of Wyoming, appellate jurisdiction of this matter lies with the Tenth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

arising out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc). Failure to establish any one these elements precludes entitlement to benefits.

### *Testimony at the Hearing*

1. Claimant testified he is married to Helen Sue and has no unmarried children who are dependent on him for support. *Tr.* at 12.

2. Claimant recalled that he last worked for Shoshone Coal in Wyoming, before taking "early retirement" in February of 1999. *Tr.* at 13-14. He had worked in the mines for 19 years. *Tr.* at 13.

3. For his first six months, Claimant worked in the computer lab because Employer wanted "to set up a computerized lab that would calculate BTU of coal so that it wouldn't be taking the company's word for it that bought the coal." *Tr.* at 20 and 26. He also spent three years as a surveyer for Employer, where 50 percent of his time was spent underground. *Tr.* at 26-27. His last coal mining job was production superintendent. *Tr.* at 14. In this position, Claimant was responsible for over 200 men who "rotated through (his) shift." *Tr.* at 14. In this position, he worked ten hour shifts underground and usually worked a "minimum" of 50 hours per week. *Tr.* at 28-29. Claimant described the physical requirements of his job as follows:

> To be responsible for the entire operation and to be in each section minimum two times per shift, supply whatever was needed, and the safety of the men.

*Tr.* at 16.

4. Claimant traveled around the underground mine site using a specially-equipped Ford F-150 truck. *Tr.* at 16. However, Claimant also had to walk during his shift:

> Counsel: How much walking would you have to do during a shift, do you believe?
>
> Claimant: It would vary. Sometimes up to 2 or 3 miles. Part of my job was to walk the belt line from outside all the way to the production section and to walk the return for the long wall production section.
>
> Counsel: And how much was that?
>
> Claimant: Well, it was 2, 2 and a half miles total belt line and return.
>
> The Court: So you would walk about 2 and a half miles each shift?

> Claimant: Not including visiting the sections where you walk the entire long wall phase, which is 600 feet, maybe two or three times a shift. So it involved quite a bit of walking.

*Tr.* at 16-17.

5. Claimant stated that he worked in a "two-entry mine, which is different than the standard three-entry which has a separate entry that the mining dust goes out." *Tr.* at 29. He explained as follows:

> [W]e was only a two-entry, one of the very few that's ever been. And all of the return dust went out the same entry as the belt line manning. And we did a lot of belt work, had some development part of it on the long wall part of it.
>
> The return dust went out its own entry. It was still a two-entry when we were there, but the—we did a lot of construction of roof support while they were cutting coal.

*Tr.* at 29-30.

6. Claimant testified that he worked as a pharmacist for 15 years prior to working in the coal mining industry. *Tr.* at 18 and 21. He further stated that, at the time of the hearing, he had returned to working as a pharmacist in Oklahoma. *Tr.* at 18-20. Claimant has a bachelor of science degree in pharmacy and, even though the State of Oklahoma currently requires that a pharmacist have a doctorate, "they grandfathered the bachelor degrees to doctor degrees." *Tr.* at 19.

7. Claimant testified that he started smoking around the age of 16 or 17 years, which was the late 1950s, until he quit in 1996. *Tr.* at 21-22. During that time, he smoked a pack a day on average. *Tr.* at 22.

8. Claimant currently takes medications for hypertension, cholesterol, triglycerides, and depression. *Tr.* at 22-24. He also takes Xanax because he is "on oxygen 12 hours a day, and once you've gone all day without oxygen and put it on, you know, it brings your energy level back up, and (Xanax is) to relax you to sleep." *Tr.* at 23. Claimant further testified that he uses inhalers. *Tr.* at 24.

9. Claimant has oxygen available to him at work and when he travels. *Tr.* at 24. He has an oxygen generator at home and he "always" uses it at night. *Tr.* at 24.

10. Claimant does not have a pulmonary doctor; rather, Dr. Khorasanchian, his cardiologist, prescribes his medications. *Tr.* at 25.

***Existence of Pneumoconiosis and its Etiology***

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2004). Moreover, the regulations at 20 C.F.R. § 718.203(b) (2004) provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a

physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2004).[3]

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) (2004) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[4] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The following chest roentgenogram evidence is in the record:[5]

| ***Exhibit / Physician/ Radiological Qualifications*** | ***Date of study/ Date of reading*** | ***Film Quality*** | ***Reading*** |
|---|---|---|---|
| *Ex.* 12 Grant radiologist | 09-27-79<br>09-27-79 | readable | --; "Normal routine chest" |
| *Ex.* 6 Dyrud radiologist | 04-18-94<br>04-18-94 | readable | --; "Lungs are well expanded and appear without active disease"; "No active cardiopulmonary disease" |
| *Ex.* 6 Dyrud radiologist | 08-21-95<br>08-21-95 | readable | --; lung fields clear; "No abnormalities appreciated on PA and lateral views of the chest" |
| *Ex.* 6 Dyrud radiologist | 07-25-96<br>07-25-96 | readable | --; lung fields are clear; "No abnormalities appreciated on PA and lateral views of the chest" |
| *Ex.* 13 Killean radiologist | 07-30-96<br>07-30-96 | Readable (portable film) | --; "There are areas of atelectasis in both lung bases" |

[3] There is no autopsy or biopsy evidence in this record and the presumptions contained at §§ 718.304 - 718.306 are inapplicable such that these methods of demonstrating pneumoconiosis will not be discussed further.

[4] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

[5] A "--" under the *Reading* column of the chart indicates that the physician did not provide a specific category reading under the ILO-U/C classification system. 20 C.F.R. §§ 718.102 and 718.202(a)(1) (2004).

| | | | |
|---|---|---|---|
| *Ex.* 7 M.E. Walker radiologist | 08-02-96<br>08-02-96 | readable | --; "Bilateral infiltrates can now be seen scattered throughout both lung fields with some sparing in the right lower lobe"; may represent pneumonia or atypical edema and "clinical correlation is suggested" |
| *Ex.* 7 P. Peters radiologist | 08-05-96<br>08-05-96 | readable | --; "improving but unresolved bilateral consolidation since 2 August 96"; there is also a "small left pleural effusion, unchanged" |
| *Ex.* 6 Dyrud radiologist | 08-13-96<br>08-13-96 | readable | --; "There are infiltrates in both lungs, a new finding when compared to the previous exam"; heart size and vascularity normal |
| *Ex.* 11 Dyrud radiologist | 08-15-96<br>08-15-96 | readable | --; "There are infiltrates in both lungs, most prominent in the base of the right lung. The infiltrate in the base of the right lung has advanced . . . and there is now partial consolidation in that region . . .." |
| *Ex.* 6 Dyrud radiologist | 08-21-96<br>08-21-96 | readable | --; compare with August 15, 1996 film--"Improving infiltrates within the lungs and right sided pleural fluid" |
| *Ex.* 10 J. Rock radiologist | 09-01-96<br>09-01-96 | readable | --; complain of pain in left lung; heart size is normal; "Pulmonary changes at the left lung base worrisome for early infiltrate and possible subpulmonic pleural effusion"; "chronic pleural reaction could not be completely excluded and prior films would be of further diagnostic value" |

| | | | |
|---|---|---|---|
| *Ex.* 13 MBJ<br>unknown | 09-13-96<br>09-13-96 | readable | --; "Equivocal changes at the left lung base that could represent fibrotic reaction. However, in the proper clinical setting, basilar pneumonia could have an identical appearance" |
| *Ex.* 5 Llewellyn<br>radiologist | 07-01-99<br>07-01-99 | readable | --; no significant radiographic abnormality seen |
| *Ex.* 5 Krieger<br>radiologist | 07-03-99<br>07-03-99 | readable | --; basal atelectasis bilaterally; small bilateral pleural effusions are also suspected |
| *Ex.* 5 Lipe<br>radiologist | 07-04-99<br>07-04-99 | readable | --; left lower lung atelectasis, effusion or infiltrate; right lower lung atelectasis |
| *Ex.* 5 Kim<br>radiologist | 07-06-99<br>07-06-99 | readable | --; essentially unchanged from July 5, 1999; left pleural effusion; vascular markings appear to be increased— probably from poor inspiration; cannot exclude infiltrates in the left lower lung |
| *Ex.* 5 Lyons<br>radiologist | 07-07-99<br>07-08-99 | readable | --; Atelectasis in both lung bases |
| *Ex.* 5 Lyons<br>radiologist | 07-08-99<br>07-08-99 | readable | --; atelectasis in both lung bases; minimal interstitial pulmonary edema |
| *Ex.* 5 Krieger<br>radiologist | 07-09-99<br>07-09-99 | readable | --; no pneumothorax; atelectasis in the left lower lobe and evidence of a left effusion |
| *Ex.* 5 Lipe<br>radiologist | 07-09-99<br>07-09-99 | readable | --; no pneumothorax |
| *Ex.* 5 Sheffner<br>radiologist | 07-10-99<br>07-10-99 | readable | --; left lower lobe atelectasis; infiltrates without significant change since July 9, 1999 |
| *Ex.* 5 Madiera<br>radiologist | 07-12-99<br>07-12-99 | readable | --; "Clear lungs with mild stable cardiomegaly" |

| | | | |
|---|---|---|---|
| *Ex.* 5 Lyons radiologist | 07-14-99<br>07-14-99 | readable | --; "mild atelectasis in the left lung base" |
| *Ex.* 10 Howard radiologist | 08-18-99<br>08-18-99 | readable | --; compare to August 31, 1996 study; mild cardiac enlargement; mild to moderate pulmonary vascular congestion; mild linear increased densities within both lung bases that may be related to atelectasis or secondary to pulmonary edema |
| *Ex.* 10 Campbell radiologist | 02-10-01<br>02-10-01 | readable | --; changes of chronic obstructive pulmonary disease with superimposed increased density in the right lung; exclude pneumonia; pulmonary vascularity is normal |
| *Ex.* 10 Wyant radiologist | 02-12-01<br>02-12-01 | readable | --; "Bilateral pulmonary infiltrate/edema are identified"' when compared to earlier film, "this is an acute finding" |
| *Ex.* 10 Shuller radiologist | 02-16-01<br>02-16-01 | readable | --; compared to February 12, 2001 film, "there has been considerable yet incomplete clearing of the previous described changes in the lung fields"; "No new areas of involvement (are) identified)"; pneumonia and congestive heart failure |

| | | | |
|---|---|---|---|
| *Ex.* 5 Girard<br>radiologist | 03-27-02<br>03-27-02 | readable | --; heart size within normal limits, no definite pulmonary vascular congestion or pleural effusion; some prominent interstitial markings in left perihilar region could be post-surgical or post-inflammatory; no evidence of pneumonia and no pneumothorax; "Bronchovascular markings in the upper portion of the right lung are less than on the left, probably representing some emphysematous disease"; evidence of obstructive pulmonary disease in the right upper lobe; no definite, acute cardiopulmonary pathology detected |
| *Ex.* 10 Wyant<br>radiologist | 01-06-03<br>01-06-03 | readable | --; "chronic appearing changes"; "The lungs appear clear with pulmonary fibrotic change"; "A large bulla is noted in the right upper lobe" |
| *Dx.* 17 Copeland[1]<br>BCR | 12-04-03<br>12-04-03 | 1 | --; heart size is normal; there are no masses; both lungs are fully expanded and clear; normal chest |
| *Dx.* 18 Navani<br>B, BCR | 12-04-03<br>12-27-03 | 2 | Read for quality purposes only |
| *Dx.* 43 Repsher<br>B | 04-27-04<br>04-27-04 | 2 | 0/0; no pleural or parenchymal abnormalities consistent with pneumoconiosis |
| *Ex.* 1 Wiot<br>B, BCR | 04-27-04<br>04-27-04 | 2 | --; no evidence of coal workers' pneumoconiosis |

[1] At the hearing, Employer offered Dr. Jerome Wiot's negative February 16, 2004 interpretation of the December 4, 2003 study conducted by the Department as evidence. *Dx.* 34. Although this exhibit was admitted at the hearing, further consideration of the evidence in light of the evidentiary limitations at 20 C.F.R. § 725.414 (2004) leads the undersigned Administrative Law Judge to conclude that it is inadmissible in this claim. Notably, since the Department's study was interpreted by Dr. Copeland, a board-certified radiologist, as not demonstrating the presence of pneumoconiosis and the regulations only permit submission of "rebuttal" evidence, Employer's negative interpretation by Dr. Wiot is excluded from the record.

Based on the foregoing, the miner has not established that he suffers from pneumoconiosis. Specifically, none of the studies yielded a finding of Category 1 or greater opacities as required by the regulations. Indeed, the most recent study dated April 27, 2004 was interpreted by Dr. Wiot, a dually-qualified physician, and Dr. Repsher, a B-reader, as negative for the presence of pneumoconiosis.

Claimant may also establish that he suffers from the disease by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). The following medical reports were admitted as evidence in the record:

1. Dr. Rodney Odgers examined and tested the miner and issued a report on December 4, 2003. *Dx.* 12. He noted 19 years of coal mine employment as well as a history of smoking one pack of cigarettes per day from 1958 to 1995. The miner complained of daily wheezing (mostly after exertion), for which he used inhalers. He also complained of ankle edema, but stated that he had not suffered from paroxysmal nocturnal dyspnea since he used oxygen at night while sleeping. Claimant reported that he becomes short of breath while climbing stairs, he cannot lift or carry any item over 20 pounds, and his oxygen level drops after walking 200 yards. Examination of the lungs revealed distant breath sounds and rhonchi at the right lung base. The chest x-ray indicated evidence of "old bypass" surgery. Ventilatory testing produced evidence of obstructive disease with a bronchodilator response. Blood gas studies demonstrated moderate hypoxia that increased with exercise. Dr. Odgers diagnosed atherosclerotic heart disease, chronic obstructive pulmonary disease arising from tobacco use, and "probable pneumoconiosis" due to coal mining. He further concluded that the miner suffered from "marked impairment" as evidenced by "desaturation (with) light exercise." When asked about the etiology of the miner's respiratory or pulmonary disease, Dr. Odgers stated:

> COPD would be considered moderate and does show response to bronchodilator. PCO2 is in normal range. (Patient) is hypoxical (at) rest (and it decreases with) exercise.

2. Dr. Lawrence Repsher examined and tested the miner on April 27, 2004, reviewed certain medical records, and issued a report on June 21, 2004. *Dx.* 43. He noted 19 years of coal mine employment as well as a history of smoking one pack of cigarettes for 35 years before quitting in

1994. Dr. Repsher stated that the miner "complains of progressive to stable dyspnea on exertion since at least 1996, as well as a nonproductive cough." The miner denied a history of asthma, and has been told that he suffers from "emphysema only." Claimant reported that skin tests for tuberculosis were negative. He has had hypertension since 1995 and is on medications for the condition. Dr. Repsher noted that the miner's EKG produced results "consistent (with) ischemic heart disease." On examination of the lungs, Dr. Repsher noted that "breath sounds are markedly diminished" and the "expiratory phase is prolonged," but there were no rales, rhonchi, or wheezes. A chest x-ray was interpreted as demonstrating Category 0 pneumoconiosis. Dr. Repsher noted some "discoid atelectasis in the right lower zone of no clinical significance." Ventilatory testing produced evidence of moderately severe chronic obstructive pulmonary disease and he noted "there is an apparent immediate bronchodilator response, which may be more due to variation and effort, rather than a true pharmacologic response to the bronchodilator." Blood gas testing revealed "moderate hypoxemia without CO2 retention." Dr. Repsher concluded the following:

> [T]he moderate COPD on pulmonary function tests and qualifying blood gases on exercise are overwhelmingly most likely related solely to his long and heavy cigarette smoking habit and are not related, to any individually measurable extent, to his work as a coal miner with exposure to coal mine dust.

Dr. Repsher found that the miner did not suffer from coal workers' pneumoconiosis and there was no evidence that he suffered from any other pulmonary or respiratory disease or condition that was either caused by, or aggravated by, his employment as a coal miner. He further opined that the miner suffers from coronary artery disease as well as moderately severe chronic obstructive pulmonary disease secondary to his history of cigarette smoking. Dr. Repsher concludes that the miner's hypertension is of unknown etiology and is "poorly controlled" despite therapy. He states that the miner suffers from neither clinical or legal pneumoconiosis because there is no radiological evidence of the disease and ventilatory abnormalities are purely obstructive "which are typical of cigarette smoking induced chronic obstructive pulmonary disease and would be extraordinarily unlikely to be the result of inhalation of coal mine dust." Moreover, Dr. Repsher posits that blood gas testing revealed hypoxemia with associated "normocarbia" whereas coal workers' pneumoconiosis, when significantly present, will produced "hypoxemia with hypocarbia." Dr. Repsher states that the miner suffers from a myriad of medical conditions, but none of them can be attributed to his coal mine employment; rather, the conditions are "primarily related to heredity and lifestyle factors."

Dr. Repsher was deposed on April 6, 2005.[2] *Ex.* 16. He testified that, over the years, he has examined 2,000 to 3,000 miners. *Ex.* 16 at 5. Dr. Repsher reiterated that the miner does not suffer from coal workers' pneumoconiosis; rather, the miner's shortness of breath developed following an acute myocardial infarction and the miner has had "stable shortness of breath since at least 1996." *Ex.* 16 at 15.

Dr. Repsher stated that, during his examination of the miner, he noticed "marked diminished" breath sounds, which suggests the presence of emphysema. *Ex.* 16 at 22.

[2] At the hearing, it was determined that the record would be held open for admission of Dr. Repsher's deposition testimony. *Tr.* at 30.

Moreover, the prolonged expiratory phase noted during the examination, suggests the presence of chronic obstructive pulmonary disease. *Ex.* 16 at 22. The discoid atelectasis on chest x-ray reported by Dr. Repsher was, in his opinion, "probably a post-operative change from the . . . heart surgery." *Ex.* 16 at 24. Dr. Repsher stated that hypoxemia experienced by the miner was consistent with findings of chronic obstructive pulmonary disease and heart disease. *Ex.* 16 at 30. He concluded that the miner's respiratory impairment and reduced diffusing capacity were due solely to his smoking history. *Ex.* 16 at 30-32. Moreover, Dr. Repsher testified that the miner's reduced blood gas study results were the consequence of congestive heart failure because "[t]he interstitium of the lung, the alveolar walls are filled up with blood and water and, therefore, you can't diffuse oxygen as well through the alveolar capillary membrane." *Ex.* 16 at 33.

Dr. Repsher concluded that Claimant suffers, primarily, from cardiac disease, "He may have had some respiratory treatments for his COPD, but I think most of his hospital records were for his heart disease." *Ex.* 16 at 36. Dr. Repsher further stated that the miner's lung disease "is due to smoking, and that certainly contributes to his shortness of breath, and his heart disease is very significant with . . . chronic congestive heart failure, and that's by far the most common cause of shortness of breath in the United States." *Ex.* 16 at 36.

Dr. Repsher is board-certified in internal medicine and pulmonary diseases with a subspecialty in critical care. He is also a B-reader and serves as an Associate Clinical Professor of Medicine at the University of Colorado. In 1982, he wrote an article titled "Evaluation of Impairment/Disability Secondary to Respiratory Disease" for the American Review of Respiratory Disease. He has written or edited chapters of medical books on respiratory diseases and attended symposia on asthma, chronic obstructive pulmonary disease, and the effects of smoking.

3. Dr. Joseph J. Renn III conducted a review of certain medical records and issued a report on February 14, 2005. *Ex.* 3. He noted 19 years of coal mine employment as well as a 35 to 42 pack year cigarette smoking history where the miner quit on August 29, 1995. Dr. Renn concluded that Claimant suffered from smoking-induced pulmonary emphysema with "probable concomitant asthma." Dr. Renn noted that, based on his review of the miner's medical records, the miner suffered from "several episodes of acute bronchitis" from 1986 to 2004. A ventilatory study conducted on February 15, 2001 during the miner's hospitalization yielded findings of congestive heart failure and pneumonitis, but the study did not "represent (Claimant's) true baseline state for which reason it should not be accorded further attention." However, Dr. Renn stated that "[t]he ventilatory function represented by the latter three studies is moderately severe but significantly bronchoreversible obstruction." A lung volume study revealed hyperinflation and marked air trapping, which was consistent with obstructive airway disease caused by emphysema. Moreover, the miner's diffusing capacity was moderately reduced and "remained so when corrected for alveolar volume." Dr. Renn concluded that the miner suffered from a moderately severe and significantly bronchoreversible obstructive ventilatory defect caused by smoking-induced pulmonary emphysema and "probable concomitant asthma." He stated that the miner's emphysema also caused "exercise-induced hypoxemia." Dr. Renn further diagnosed the presence of Adult Respiratory Dysfunction Syndrome (ARDS), but concluded that the miner did not suffer from legal or clinical coal workers' pneumoconiosis. With regard to cardiovascular

diagnoses, Dr. Renn concluded that Claimant had artherosclerotic coronary vascular disease, chronic congestive heart failure owing to diastolic dysfunction, and systemic hypertension. He noted that the miner had a triple coronary artery bypass graft as well as an old myocardial infarction. Dr. Renn opined that the miner was totally disabled due to "tobacco smoke-induced pulmonary emphysema and probable concomitant asthma rather than exposure to coal mine dust."

Dr. Renn was deposed on March 17, 2005. *Ex.* 15. He is board-certified in internal medicine, pulmonary diseases, forensic medicine, and as a forensic examiner. *Ex.* 15 at 3. Dr. Renn explained that a forensic examiner "[e]xamines individuals for questions of a legal aspect, usually a medicolegal aspect." *Ex.* 15 at 3. He testified that forensic medicine is "medicine as it relates to any legal question and, in my case, it is restricted to questions of pulmonary and occupational lung disease." *Ex.* 15 at 3. Dr. Renn is also a NIOSH-certified B-reader. *Ex.* 15 at 3. He noted that "[a]t least a third of (his) practice was either coal miners or retired coal miners throughout the almost 40 years (he) practiced medicine," but that he retired from active patient care in January 2003. *Ex.* 15 at 7-8. Currently, he is "only now engaged in the forensic medicine practice and anything associated with that." *Ex.* 15 at 8.

In rendering his opinion in this claim, Dr. Renn testified that he has considered the "clinical and legal definitions of pneumoconiosis" and notes that the disease is progressive and latent and may first become detectable after cessation of coal dust exposure. *Ex.* 15 at 16. He testified that the miner suffered from "pulmonary emphysema as a result of tobacco smoking" and "probable concomitant asthma . . . because he had significantly bronchoreversible airway obstruction." *Ex.* 15 at 20-21. Dr. Renn also opined that Claimant had "adult respiratory dysfunction syndrome and that's extremely important . . . because the person with adult respiratory dysfunction syndrome does not always recover their normal or baseline ventilatory function." *Ex.* 15 at 21. Dr. Renn explained that the miner developed ARDS "after he had triple coronary artery bypass grafting" and, at that time, he also suffered from dysfunction of certain other organs such as acute renal failure, "post-operative pleural effusion," atelectasis of the left lower lobe (which is not uncommon after bypass grafting), and anemia. *Ex.* 15 at 21 and 23-24.

Dr. Renn stated that heart surgery can cause ARDS and he reasoned as follows in support of this opinion:

> [I]t can be any insult that occurs and then, for some reason which we don't fully know, there is a leaking of fluid into the interstitium of the lung and it interferes with gas exchange.
>
> You get these diffuse infiltrates. In fact, there are radiographic criteria for ARDS that you have two or three lobes involved usually on the opposite sides of the chest and then this results in interference with gas exchange to the extent that you have to use a ventilator with positive and expiratory pressure in order to adequately oxygenate the person and attempt to carry them through the insult.

*Ex.* 15 at 24.

Dr. Renn reported that increased health risks due to smoking include "serious cardiovascular diseases, serious lung diseases such as chronic bronchitis and emphysema, cancers of the respiratory tract and also of the oral cavity and also cancer of the urinary bladder." *Ex.* 15 at 41-42. In this case, Dr. Renn states that the miner has "developed serious heart disease and he's also developed pulmonary emphysema as a result of his tobacco smoking." *Ex.* 15 at 42.

Upon review of the miner's records, Dr. Renn noted the following with regard to various physical examinations:

> Sometimes he had normal signs. Sometimes there were rhonchi, which are large airway wheezes. He had crackles sometimes. He had wheezes, which are . . . small airway sounds, that are abnormal.
>
> He had diminished breath sounds which are found in people who have hyperinflation such as asthma, asthmatics and also people with emphysema.
>
> He had prolongation of the expiratory phase, which is seen in people that have obstructive airway disease and he had a hyper-resonant percussion note which is usually found in people with either asthma or emphysema.

*Ex.* 15 at 44-45. Dr. Renn also stated that, although Claimant had various findings associated with cardiac disease, there were no findings of cor pulmonale. *Ex.* 15 at 45-46. He noted that 2003 and 2004 ventilatory testing demonstrated "moderately severe obstruction with significant bronchoreversibility" and, indeed, the obstruction reversed from moderately severe to moderate. *Ex.* 15 at 46. Dr. Renn opined that there is not "significant bronchoreversible airway obstruction in a coal mine dust-induced disease." *Ex.* 15 at 47.

Dr. Renn further states that there are "different degrees of obstruction from emphysema caused by tobacco smoking":

> As we see in Mr. Freeman, he has a moderately severe but significantly bronchoreversible obstruction. It reverses to being a moderate obstruction, which is the asthmatic part of the obstructive airways disease, so his emphysema has progressed to moderately severe.
>
> In a person who has emphysema established, even if they quit smoking, it will continue to progress . . ..

*Ex.* 15 at 49. He further stated that the April 27, 2004 lung volume study:

> . . . tells you that he has hyperinflation and marked air trapping and that lung volume study is completely inconsistent with coal workers' pneumoconiosis.
>
> Coal workers' pneumoconiosis cause a mild reduction in the total lung capacity but not below 90 percent of predicted and it causes an elevation of the residual

> volume but not above 120 percent of predicted; whereas pulmonary emphysema caused by tobacco smoking, it is a classic pattern that they develop an elevated total lung capacity above 120 percent of predicted and a disproportionately elevated residual volume indicative of the air trapping from the emphysema.

*Ex.* 15 at 51. Moreover, Dr. Renn reported:

> Mr. Freeman had a diffusing capacity which was moderately reduced. That is indicative of a person who has emphysema. It is characteristic of a person with emphysema because of the loss of gas exchange surface. In other words, if there's destruction of the lung, then the diffusing capacity will be reduced.

*Ex.* 15 at 52. In this vein, Dr. Renn stated that, generally, Claimant had normal blood gas study values at rest, but the values became abnormal after exercise because "when (Claimant's) metabolic demand goes up when he tries to exercise, the lungs and heart don't work well enough to supply him with adequate oxygenation for the degree of exercise he is doing." *Ex.* 15 at 53.

In sum, Dr. Renn concludes that the miner's respiratory impairment is due solely to cigarette smoking and not coal workers' pneumoconiosis because: (1) on examination, wheezing was heard; (2) there is no chest x-ray evidence of coal workers' pneumoconiosis; (3) physiological studies show a pattern consistent with tobacco-smoke-induced pulmonary emphysema and the pattern is not consistent with the presence of coal workers' pneumoconiosis; (4) studies revealed a disproportionate reduction of the volumes and flows that is inconsistent with coal workers' pneumoconiosis; (5) the miner exhibited marked elevation of the residual volumes of his lungs; (6) his diffusing capacity was moderately reduced, which is consistent with emphysema and not coal workers' pneumoconiosis; and (7) ventilatory testing revealed bronchoreversibility, which is indicative of asthma. *Ex.* 15 at 55-57. Dr. Renn stated that Claimant could not perform his last coal mining job due to "exercise-induced hypoxemia" arising from smoking-induced pulmonary emphysema. *Ex.* 15 at 58.

4. Numerous hospitalization and treatment records have been admitted as evidence in this matter.

***Ex.* 6** **Hanna Energy Basin Clinic**

The earliest recorded complaint of shortness of breath occurred at the Hanna Energy Basin Clinic on May 22, 1986. There are various cardiac and respiratory symptoms and events recorded in the Clinic's records:

| | |
|---|---|
| August 21, 1995 | examination of the lungs revealed pronounced rales and coughing, but no wheezing |
| August 29, 1995 | "Congrats on stopping smoking" |
| November 25, 1995 | complaints of dyspnea |

| | |
|---|---|
| February 27, 1996 | miner advised that Dr. Cole said he had suffered from "two small strokes" |
| August 13, 1996 | miner suffered a heart attack |
| October 1, 1996 | miner complained of persistent chest pain |
| May 12, 1997 | recommended that miner see a cardiologist; complains that it is difficult to breathe at night and that he has problems with breathing, mainly on expiration and it can "occur with exercise or sitting in a recliner"; miner also states that he is able to hear himself wheeze at times and that he had the "same feeling (with) bronchitis years ago" |
| May 15, 1997 | the miner complained of shortness of breath with activity but that use of a inhaler "opens up" his lungs |
| May 28, 1997 | the miner experienced more shortness of breath; a 40 year history of smoking one pack of cigarettes per day was reported, where the miner quit in August 1995; the miner was diagnosed with chronic obstructive pulmonary disease |
| June 24, 1997 | miner still complains of shortness of breath; blood pressure not good; still smoking |
| July 29, 1997 | it was noted that the miner was "feeling good, doesn't have any problem breathing but every once in a while feels like he has to take an extra breath"; shortness of breath "less of a problem" |

***Ex.* 11 Memorial Hospital of Carbon County**

On April 3, 1995, Dr. Kenneth Schulze noted that Claimant arrived by ambulance for a crushed hand injury. Examination of the heart and lungs produced normal results.

Dr. D.E. Abels submitted a report for an emergency room admittance on August 21, 1995. Examination of the lungs revealed "rales in the lower fields particularly on the right side with expiratory wheezing on both sides particularly on the right side also in the right middle lobe." A chest x-ray reportedly "just shows smokers lungs." Dr. Abels diagnosed bronchitis with a bronchospasm and he "[e]xplained to the patient that he has to quit smoking" and he stated that he was "greatly concerned about whether how much COPD is underlying these problems that (Claimant) is having."

According to Dr. V. Chandra, the miner was hospitalized on July 25, 1996 for myocardial infarction, hypertension, and an unstable angina.

The miner was hospitalized from August 13, 1996 to August 16, 1996. Dr. Stephen Dalton wrote the discharge summary where Claimant was diagnosed as suffering from

pneumonia with hypoxia and atherosclerotic heart disease. In the report, Dr. Dalton noted that the miner had been recently discharged from the Wyoming Medical Center but, at the time of discharge, he "developed a severe pain in his left chest wall which got worse with deep inspiration." A chest x-ray revealed "advancing infiltrates in the right lung" and Claimant advised that he had undergone angioplasty to the "same vessel several times last week." Claimant had reported that he quit smoking one year earlier and was employed as a shift supervisor at a mine in Hanna. Examination of the lungs revealed "crackles in all lung fields" with no wheezing. The heart examination revealed regular rate and rhythm with no murmurs, clicks, rubs, or gallops.

***Ex.* 7 Wyoming Medical Center**

The miner was hospitalized from July 26, 1996 until August 11, 1996. In the October 6, 1996 discharge summary, Dr. Robert Novick diagnosed Claimant as suffering from acute non-Q wave myocardial infarction, history of hypertension, history of lacunar type cerebrovascular accident, hypercholesterolemia, history of bronchitis, cigarette smoking, and coagulopathy. Dr. Novick noted that, three weeks prior to admission at the Center, the miner stated that he developed exertional chest pain while walking up a hill. He described the pain as "substernal chest pressure radiating to his left shoulder" that would resolve with rest.

Testing on July 26, 1996 confirmed the presence of proximal right coronary artery disease and 30 percent stenosis "of the left main with diffuse mild irregularities of the left anterior descending and circumflex." A ventilation perfusion lung scan dated August 2, 1996 revealed that "[g]reater than 50% of the lungs show matched ventilation and perfusion defects," which resulted in a determination that the scan was "indeterminate."

Dr. Novick reported that Claimant was a coal miner in an underground mine and he smoked a pack of cigarettes per day for 35 years until quitting one year ago. The miner denied a history of tuberculosis, asthma, chronic cough, emphysema, or wheezing. On admission, his lungs were clear, but his cardiac examination produced "irregular" results. Discharge instructions included a recommendation that Claimant not smoke and that he "avoid smoke-filled rooms."

On May 19, 1997, Dr. Novick issued a report after a follow-up to the 1996 myocardial infarction and noted that the miner had been "doing well" since his August 1996 hospitalization. *Ex.* 8. Dr. Novick noted some shortness of breath, but no dizziness, during the visit. He stated that the miner had no anginal symptoms. Examination of the lungs revealed expiratory wheezes at both bases and cardiac examination produced findings of "regular rate and rhythm." Dr. Novick concluded that "[i]t appears that the patient's shortness of breath is more bronchial than cardiac" and he could "find no evidence of (cardiac) failure at this time."

***Ex.* 13 Warren (McAlester) Clinic**

A ventilation perfusion lung scan was conducted on August 2, 1996 and Dr. S.R. Horn concluded that it revealed "indeterminate results."

On September 4, 1996, Dr. Larry Lewis diagnosed Claimant with coronary artery disease and pleurisy with questionable pneumonia. Examination of the lungs revealed crackles in the lower lung bases. Dr. Lewis cited to a number of "risk factors" including hypertension, sedentary lifestyle, and that Claimant had a 40 pack year smoking history, but quit one year ago. It was further noted that the miner had a history of two strokes, angina, and a myocardial infarction, but no congestive heart failure. He was referred to Dr. Francis Oliver, a cardiologist, in Oklahoma.

By report dated September 20, 1996, Dr. Oliver diagnosed Claimant with "chest discomfort" and coronary artery disease. He noted that the miner suffered from chronic bronchitis and had a history of chronic obstructive pulmonary disease, but was "off cigarettes."

On September 2, 1998, Dr. Kern Jackson issued a report after a follow-up visit regarding Claimant's cardiac condition. He noted no complaints of chest pain or tightness, but that the miner suffered from "slight" shortness of breath. The lungs were clear on examination. The heart had regular rate and rhythm. Dr. Jackson diagnosed the presence of coronary artery disease (with a 1996 hospitalization for angioplasty), chronic obstructive pulmonary disease, hypertension, and hypercholesterolemia. With regard to the diagnosis of chronic obstructive pulmonary disease, Dr. Jackson noted a 40 year smoking history as well as 19 years of coal mine employment. He reported that the miner complained of shortness of breath with activity. Claimant advised Dr. Jackson that he was told that ventilatory testing conducted in January in Wyoming was "better" that testing conducted previously. Examination of the lungs revealed diminished breath sounds without wheezing, rales, or rhonchi. The heart demonstrated regular rhythm.

A stress thallium scan was conducted on September 8, 1998 and Dr. Kathy Wyant concluded that there were "[f]indings consistent with infarct involving the inferior wall with extension into the apex" and that there "may be some ischemia involving the anterior wall."

On March 15, 1999, Dr. Larry Lewis reported that the miner suffered from coronary artery disease, hypertension, and cervical pain and discomfort. The lungs were clear on examination and a cardiac examination revealed regular rhythm. The miner was diagnosed with coronary artery disease, possible angina pectoris syndrome, hypertension, hypercholesterolemia, and chronic obstructive pulmonary disease.

***Ex.* 10 McAlester Regional Medical Center**

On August 31, 1996, the miner was admitted with left lung pain and was diagnosed with pleurisy.

On September 19, 1996, Claimant underwent a treadmill test and a Thallium Myocardial Study was indicated. The Study revealed an inferior myocardium with surrounding ischemia. The interpreting physician noted that a "portion of the findings may be due to attenuation by the diaphragm."

On September 8, 1998, Dr. Wyani interpreted a Stress Thallium Scan and concluded that there were "findings consistent with infarct involving the interior wall with extension to the apex" and "[t]here may be some ischemia involving the anterior wall."

On August 18, 1999, the miner was examined because of complaints of shortness of breath. Dr. Khorasanchian concluded that Claimant suffered from congestive heart failure, tachycardia, ischemia, and artherosclerotic heart disease. He further marked a box on the report form indicating that the miner's "[g]as exchange (was) impaired."

***Ex.* 5** **St. Francis Hospital**

On June 29, 1999, Dr. John Waters stated that the miner arrived at the Hospital complaining of recurrent chest pain. He reported that the miner smoked one pack of cigarettes per day for 40 years, until he quit in 1995. The lungs were "[c]lear to percussion and auscultation" on examination. Dr. Waters noted that Claimant had a history of worsening angina pectoris, which is predominantly exertional. He diagnosed hyperlipidemia, hypertension, and remote tobacco abuse.

The miner was hospitalized from July 1, 1999 until July 19, 1999 and Dr. Gregory Hill issued the discharge report on September 30, 1999. During the period of the miner's hospitalization, variable lung sounds were noted—sometimes the lungs were "clear," but sometimes crackles, wheezes, or diminished breath sounds were heard. Dr. Hill diagnosed unstable angina, coronary disease, respiratory failure secondary to adult respiratory distress syndrome, acute renal failure, post-operative anemia, hypertension, hyperlipidemia, post-operative atelectasis, and post-operative pleural effusion. During this period of hospitalization, Dr. W. Mark Boomer provided a consultative report dated July 3, 1999 for complaints of progressive dyspnea. Dr. Boomer noted a 20 pack year smoking history and occupational exposure as a coal miner in Wyoming. He stated that the miner suffered from moderate to severe respiratory distress on examination, but the oxygen saturation was "currently adequate." Examination of the lungs revealed "[d]ecreased breath sounds associated with bilateral wheezes." The heart examination produced findings of "[r]egular rate and rhythm without murmur or gallops." A chest x-ray demonstrated the presence of atelectasis. Dr. Hill stated that he could not be "totally certain whether (the progressive dyspnea) is related to his lower respiratory track infection and/or atelectasis." He stated that "[o]ther possibilities would include congestive heart failure although this seems to be relatively unlikely at this point." The miner suffered from a history of smoking, but stopped in 1995. Dr. Hill diagnosed the presence of "probable asthma and/or emphysema."

On March 27, 2002, Dr. Waters issued an admitting report stating that Claimant arrived at the Hospital with symptoms "suggestive of angina pectoris and Dr. Khorasanchian (his cardiologist) sent him to St. Francis Hospital for possible revascularization." The miner was diagnosed with hypertension, hyperlipidemia, previous myocardial infarction, and recurrent angina. He underwent cardiac testing and catheterization.

***Ex.* 9** **McAlester Regional Hospital**

The miner was hospitalized from February 10, 2001 until February 19, 2001 under the care of his cardiologist, Dr. Khorasanchian. Claimant was admitted for congestive heart failure, pneumonia, hypoxia, and artherosclerotic heart disease. Examination of the lungs revealed rhonchi but, "in the beginning," no wheezing was heard. A lung scan perfusion was conducted on February 12, 2001 and Dr. Melton James, a radiologist, concluded that the scan demonstrated "normal blood flow bilaterally without evidence of a pulmonary embolis." His impression was that the scan was "normal."

In his February 19, 2001 discharge summary, Dr. Khorasanchian diagnosed Claimant with severe hypoxia, pneumonitis, congestive heart failure, severe atherosclerotic heart disease, hyperlipidemia, longstanding hypertension, and depression. He also noted that the miner had previously suffered from a myocardial infarction and had undergone a coronary artery bypass graft and angioplasty, which was complicated by severe hypoxia in 1999. Dr. Khorasanchian further stated that the miner had a history of "working in the coal mines with pneumoconiosis" as well as a history of tobacco abuse. On admission, the miner had complained of severe shortness of breath, a non-productive cough, and wheezing. A chest x-ray revealed possible pneumonitis and symptoms of congestive heart failure. Moreover, Dr. Khorasanchian noted that Claimant had "severe wheezes, rales and rhonchi which was markedly improved after starting antibiotics and asthma treatments." By February 19, 2001, Claimant's "color (was) much better, (and his) chest (was) markedly clear."

Dr. Brian Worley examined the miner during a follow-up visit and issued a report on March 7, 2001. He noted that the 60 year old patient had been admitted for shortness of breath and pneumonia. A chest x-ray revealed "diffuse interstitial infiltrates consistent with pneumoconia." Dr. Worley noted that the miner did not complain of chest pain or angina. He further reported a history of coronary artery disease and angioplasty in 1995 with bypass surgery in 1999. Dr. Worley stated that Claimant "currently smokes one pack of tobacco a day" and "works as a pharmacist." When he reviewed the x-rays conducted from February 1 through February 16, 2001, Dr. Worley found that the diffuse, bilateral interstitial infiltrates "have shown continuous clearing up to the 16th; however, (Claimant) has mild persistent interstitial infiltrates in his bilateral lower lobes." Dr. Worley diagnosed the presence of severe emphysema.

***Ex.* 12 and 14; *Dx.* 13 Treatment notes of Dr. Abdolkarim Khorasanchian**

| | |
|---|---|
| June 23, 1999 | Dr. Khorasanchian noted that Claimant used to smoke one pack of cigarettes per day before quitting in 1995. He also noted that the miner suffered from coronary artery disease and, in 1996, he suffered from a myocardial infarction with angioplasty performed 24 hours later. Dr. Khorasanchian stated that "[t]he patient has been having some problems with some discomfort in the chest" and he "gets short of breath easily and (gets) tired very easily." Heart sounds were normal and lungs were "clear" with no rales or wheezing. |
| June 29, 1999 | Dr. John H. Waters issued a consultative report. He reported a 40 pack year smoking history, which ended in 1995. Claimant's occupational history was not reported. The miner complained of recurrent chest pain. Dr. Waters noted a history a emphysema and that the miner does not exercise due to |

| | |
|---|---|
| | shortness of breath. The lungs were "clear to percussion and auscultation" on examination. Cardiac examination revealed no "appreciable murmur, rub or gallop." Dr. Waters noted that the miner had a history of worsening angina pectoris that was predominantly exertional. He further reported a previous inferior myocardial infarction, hyperlipidemia, hypertension, and remote tobacco abuse. Dr. Waters scheduled the miner for a coronary arteriogram. |
| August 12, 1999 | Dr. Khorasanchian noted that the miner was hospitalized for 19 days, mostly on a respirator. The miner had been doing well since the time of his discharge but, at times, continues to suffer from shortness of breath. The lungs were clear, but the heart revealed an S3 gallop. |
| March 7, 2001 | Dr. Brian Worley of the Pulmonology Clinic issued a consultative report. He noted that the miner's chief complaint was "pneumonia" and that Claimant was recently hospitalized for shortness of breath and pneumonia. Dr. Worley stated that x-ray studies from February 1 through February 16, 2001 revealed "diffuse interstitial infiltrates consistent with pneumonia." The x-rays further revealed "continuous clearing" by February 16th, but the miner still had "mild persistent interstitial infiltrates in his bilateral lower lobes. Ventilatory testing yielded evidence of an 11 percent increase with the use of bronchodilators. Dr. Worley also noted that the miner continues to experience shortness of breath and uses oxygen 12 to 18 hours per day. Claimant did not experience chest pain or angina during the examination. Moreover, the lungs were clear to auscultation. Dr. Worley diagnosed severe emphysema, coronary artery disease, and probable atypical pneumonia. |
| March 8, 2001 | The miner was recently hospitalized for pneumonitis and asthma. Claimant was diagnosed with congestive heart failure and angina and it was noted that he continues to have "problems" with shortness of breath. |
| January 14, 2002 | Dr. Khorasanchian wrote: "This gentleman has had problems with ASHD, S/P CAPG, has had high cholesterol, has what appears to be pneumoconiosis, he had a lung function test and results are pending at this time, he has less angina since last visit, very rarely requires any NTG, chest is clear." (emphasis added) |
| March 11, 2002 | Severe coronary artery disease, asthma, chronic obstructive pulmonary disease. |
| April 22, 2002 | Claimant has had problems with artherosclerotic heart disease and is "still waiting for black lung evaluation" |
| July 24, 2002 | The miner has had problems with coronary artery disease, chronic obstructive pulmonary disease, and "black lung." His lungs were clear and his heart sounds were regular and normal. |
| February 12, 2003 | History of severe coronary artery disease, chronic obstructive pulmonary disease, and asthma. Examination of the lungs revealed a "few scattered rhonchi." It was noted that the miner recently had pneumonia, but had improved. |
| Sept. 4, 2003 | Dr. Khorasanchian states the following:<br><br>"This gentleman has been under my care for several years. He has been |

| | |
|---|---|
| | known to have severe cardiopulmonary problems including pneumoconiosis. He has severe orthopnea and develops hypoxia with the mildest exertion. In my opinion, Mr. Freeman is totally physically disabled." |
| Jan. 14, 2004 | Dr. Khorasanchian's progress notes provide that a gallop was heard during the cardiac examination. Moreover, examination of the lungs revealed scattered rhonchi and expiratory wheezes. Dr. Khorasanchian diagnosed influenza "with other manifestations," progressive general coronary atherosclerosis, stable congestive heart failure, chronic hypercholesterolemia, stable general asthma, and chronic hypertension. |
| April 14, 2004 | At this check-up, Dr. Khorasanchian noted a history of chronic obstructive pulmonary disease and coronary disease. Examination of the lungs revealed scattered rhonchi and expiratory wheezes. An S3 gallop was heard on examination of the heart. Dr. Khorasanchian diagnosed general asthma, congestive heart failure, chronic hypertension, coronary atherosclerosis, stable coal workers' pneumoconiosis, and chronic hypercholesterolemia. |
| May 17, 2004 | Examination of the lungs revealed scattered rhonchi and expiratory wheezes. An S3 gallop was noted on cardiac examination. Dr. Khorasanchian diagnosed stable coal workers' pneumoconiosis, acute, exacerbated bronchitis, stable coronary atherosclerosis, and chronic hypercholesterolemia.<br><br>Dr. Khorasanchian wrote the following:<br><br>"This gentleman has a problem with pneumoconiosis and coronary artery disease. He continues to have symptoms of hypoxia with exertion and at times has orthopnea, symptoms of asthma.<br><br>Lab test results show he has abnormal single breath diffusing capacity (DLCO).<br><br>It appears that his symptoms are more related to his lung problems and not to his coronary disease.<br><br>His ejection fraction is 65%." |
| Aug. 27, 2004 | Dr. Khorasanchian writes the following:<br><br>"James Freeman has been a patient of mine for several years. He has developed multiple medical problems including pneumoconiosis, asthma, congestive heart failure, diastolic dysfunction, hypoxia, and ASHD. He is working as a pharmacist and is trying to continue to be active. His oxygen saturation goes down when he is active and he therefore uses oxygen. In order to continue working as a pharmacist, Mr. Freeman needs oxygen available at his place of employment. He wants to remain active so he needs portable oxygen also." |
| Sept. 15, 2004 | Examination of the lungs revealed no evidence of rhonchi. The miner did exhibit expiratory wheezing. Cardiac examination produced findings of an |

| | |
|---|---|
| | S3 gallop. Dr. Khorasanchian diagnosed a cough, stable coal workers' pneumoconiosis, chronic hypercholesterolemia, and chronic hypertension. |
| Dec. 6, 2004 | No diagnoses were listed on this progress note. However, an S3 gallop was reported on cardiac examination. Examination of the lungs revealed no rhonchi or expiratory wheezes. |

Discussion of the medical opinion evidence

Of the physicians' reports of record, the miner's cardiologist, Dr. Khorasanchian, concluded that he suffers from coal workers' pneumoconiosis in addition to other respiratory and cardiac conditions. Dr. Jackson, in his September 1998 consultative report for the Warren (McAlester) Clinic, alludes to the fact that smoking and coal dust exposure possibly contributed to development of Claimant's chronic obstructive pulmonary disease. Dr. Odgers opined that Claimant suffers from tobacco-induced chronic obstructive pulmonary disease and "probable pneumoconiosis." On the other hand, Drs. Repsher and Renn state that the miner suffers from neither clinical nor legal pneumoconiosis. Rather, they conclude that Claimant's respiratory impairment stems from the effects of long-term tobacco abuse and cardiac disease.

Based on a review of the data underlying his report, Dr. Odgers' opinion carries little probative value. Specifically, a diagnosis of "probable pneumoconiosis" is too equivocal to establish presence of the disease under the regulations. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (physician's opinion was too equivocal and entitled to little weight where he concluded that the miner "probably had black lung disease"). Moreover, the basis for Dr. Odgers' equivocal conclusion cannot be determined. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc) (an unreasoned and undocumented report is entitled to little probative value). Although Dr. Odgers diagnosed chronic obstructive pulmonary disease, he attributed this condition to the miner's history of smoking, not coal dust exposure. None of the chest x-ray studies of record yielded findings of pneumoconiosis. Indeed, the study underlying Dr. Odgers' report was interpreted by a board-certified radiologist as revealing a "normal chest." In addition, Dr. Odgers noted that ventilatory testing produced evidence of an obstructive impairment that improved after use of a bronchodilator. Because pneumoconiosis is an irreversible disease process, a bronchodilator response on ventilatory testing militates against a finding of pneumoconiosis. 20 C.F.R. § 718.201(c) (2004) (pneumoconiosis is defined as "progressive"); *Wyoming Fuel Co. v. Director, OWCP*, 90 F.3d 1502 (10th Cir. 1996) (pneumoconiosis is progressive and irreversible); *Andryka v. Rochester & Pittsburgh Coal Co*., 14 B.L.R. 1-34 (1990). In addition, Dr. Kennedy validated the ventilatory test, but stated that the test did not produce evidence of coal workers' pneumoconiosis. Finally, Dr. Odgers noted that the miner suffered from marked impairment as evidenced by desaturation on exercise during blood gas testing. However, he seems to attribute this finding to Claimant's smoking-induced chronic obstructive pulmonary disease. In sum, Dr. Odgers' report is too equivocal and it is not well-reasoned or well-documented.

Dr. Jackson's report is likewise too equivocal to be probative. Further, Dr. Jackson provides no explanation for his equivocal findings and there is no reference to documentation or underlying medical data in support of his opinion. As a result, it is not accorded weight in support of a finding of coal workers' pneumoconiosis.

The miner's treating cardiologist, Dr. Khorasanchian, provided a definitive diagnosis of coal workers' pneumoconiosis. However, his opinion is not accorded great weight because the diagnosis of coal workers' pneumoconiosis appears in the treatment notes without explanation or reference to documentation in support of it. *See Clarke, supra.* In this vein, Dr. Khorasanchian documented complaints of shortness of breath and chest discomfort since at least 1999. During the same time period, he also reported a history of emphysema, myocardial infarction, hyperlipidemia, hypertension, and remote tobacco abuse. In 1999, Dr. Khorasanchian noted that the miner was hospitalized for two weeks on a respirator with pneumonia and related health issues. A pulmonologist's 2001 consultative report yielded diagnoses of severe emphysema, coronary artery disease, and "probable atypical pneumonia." Up to this point in time, no diagnosis of legal or clinical coal workers' pneumoconiosis was made.

For the first time, on February 19, 2001, in a discharge summary, Dr. Khorasanchian stated that Claimant had a history of "working in the coal mines with pneumoconiosis." On January 14, 2002, Dr. Khorasanchian stated in a cursory statement that Claimant "has what appears to be pneumoconiosis." There is no explanation for these statements, nor is there any underlying documentation to support the opinions. Subsequent notes and letters from Dr. Khorasanchian contain a diagnosis of "coal workers' pneumoconiosis" or "black lung," yet there continues to be a lack of explanation or documentation in support of the diagnosis.

Examinations of the miner's lungs throughout this time period produced variable findings. On some occasions, rales, rhonchi, or wheezing was heard but, on other occasions, the lungs were clear on examination. This variability is inconsistent with the presence of an irreversible disease process such as pneumoconiosis. Moreover, as previously noted, no consultative pulmonology report in Dr. Khorasanchian's records contained a reasoned or documented finding of coal workers' pneumoconiosis.

Given that Dr. Khorasanchian is a cardiologist as opposed to a pulmonologist and his diagnosis of coal workers' pneumoconiosis is unreasoned and undocumented, his opinion is insufficient to demonstrate presence of the disease under the regulations.

On the other hand, Drs. Renn and Repsher conclude that the miner's respiratory impairment stems from smoking-induced chronic obstructive pulmonary disease and long-term cardiac disease. Initially, it is noted that these physicians are board-certified in internal medicine and pulmonary diseases and, as a result, they possess greater expertise in diagnosing the presence of absence of pulmonary or respiratory ailments than physicians without these special qualifications. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984) (the qualifications of physicians are relevant in determining the probative values to which their opinions are entitled).

Drs. Repsher and Renn conclude that Claimant does not suffer from clinical or legal pneumoconiosis. Theirs findings in this regard are supported by a preponderance of the objective medical data, *i.e.* the negative chest x-ray studies of record. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986) (it is proper to accord greater weight to an opinion that is better supported by objective medical data of record). Further, Dr. Repsher noted that the miner's blood gas testing yielded evidence of hypoxemia with "normocarbia," whereas

coal workers' pneumoconiosis would produce hypoxemia with "hypocarbia." Also, Dr. Repsher notes that Claimant's symptoms of shortness of breath developed around 1996, after he suffered a myocardial infarction. He states that congrestive heart failure is "by far the most common cause of shortness of breath in the United States." Moreover, Dr. Repsher noted marked, diminished breath sounds on his examination of the miner, which he states is indicative of smoking-induced emphysema. He concludes that the miner's congestive heart failure caused his reduced blood gas study results.

Likewise, Dr. Renn concluded that Claimant suffered from smoking-induced cardiac and respiratory diseases. In support of this opinion, Dr. Renn notes that the miner's lung volume study revealed hyperinflation and air trapping consistent with smoking-induced emphysema. Dr. Renn states that the miner developed ARDS "after he had triple coronary artery bypass grafting." This is consistent with the miner's hospitalization records. *See Minnich, supra.* Indeed, a review of those records reveals that Dr. Hill, one of the miner's hospital physicians, diagnosed respiratory failure secondary to ARDS in his September 30, 1999 discharge report at Saint Francis Hospital.

Dr. Renn posits that the diagnosis of ARDS is "extremely important . . . because the person with adult respiratory dysfunction syndrome does not always recover their normal or baseline ventilatory function." Dr. Renn noted that heart surgery, such as the surgery undergone by Claimant in this case, can cause ARDS. He explained that, after an "insult" to the body (as with surgery), diffuse infiltrates can appear on the chest x-ray and these infiltrates interfere with gas exchange to the extent that a ventilator may be required.

Dr. Renn's opinion in this regard is consistent with the miner's hospitalization and treatment records. Notes from the Hanna Energy Basin Clinic reveal that Claimant suffered a heart attack in 1996. Chest x-rays predating this event yielded evidence of "clear" lungs or "normal" chest. However, chest x-rays conducted during the miner's 1996 hospitalization for the myocardial infarction revealed the first findings of atelectasis and bilateral infiltrates. The findings of infiltrates varied in subsequent years as did the miner's respiratory symptoms. This variability is inconsistent with an irreversible disease process such as coal workers' pneumoconiosis.

Consequently, the opinions of Drs. Renn and Repsher are accorded the greatest weight on this record because of their superior qualifications as pulmonologists in diagnosing respiratory and pulmonary ailments. The fact that Dr. Khorasanchian was the miner's treating physician does not require that greater weight be accorded his opinions because they are not well-reasoned or well-documented. On the other hand, the opinions of Drs. Renn and Repsher are well-documented and well-reasoned on this record. Both Drs. Renn and Repsher had the opportunity to review a variety of hospitalization and treatment records as well as data obtained in conjunction with the Department-sponsored examination by Dr. Odgers. Dr. Renn also reviewed the examination conducted by Dr. Repsher. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984) (greater weight may be accorded an opinion that is supported by more extensive documentation). Their opinions are supported by the medical data of record and they possess specialized qualifications in the area of pulmonary medicine. Claimant has not sustained his burden of

demonstrating that he suffers from clinical or legal coal workers' pneumoconiosis under § 718.202(a) of the regulations.

***Total Disability Due To Pneumoconiosis***

Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2004). The regulations further state the following:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

20 C.F.R. § 718.204(a) (2004).

Moreover, pneumoconiosis must be a "substantially contributing cause" to the miner's total disability. 20 C.F.R. § 718.204(c)(1) (2004). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1) (2004).

Twenty C.F.R. § 718.204(b) (2004) provides the following five methods to establish total disability: (1) qualifying pulmonary function studies; (2) qualifying blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure;[6] (4) reasoned medical opinions; and (5) lay testimony.[7]

Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R.

[6] There is no evidence of cor pulmonale with right-sided congestive heart failure such that this method of establishing total disability will not be discussed further.

[7] The Board holds that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

§ 718.103 (2004) and require, in relevant part, that (1) each study be accompanied by three tracings, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), (2) the reported FEV1 and FVC or MVV values constitute the best efforts of three trials, and, (3) for claims filed after January 19, 2001, a flow-volume loop must be provided. The administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984). To be qualifying, the regulations provide that the FEV1 and either the MVV or FVC values must be equal to or fall below those values listed at Appendix B for a miner of similar gender, age, and height. The following pulmonary function studies are in the record:

| ***Exhibit/ Date of Test*** | *Physician/* ***age/height (in.) coop/comp*** | *Tracings/* ***Flow-Vol. Loop*** | ***Bronchodilator?*** | ***FEV1*** | ***FVC/MVV*** | ***Qualifies?*** |
|---|---|---|---|---|---|---|
| *Ex.* 9<br>02-15-01 | Worley<br>60/70"<br>"excellent" | Yes<br>Yes (except test halted prematurely due to "seizure" activity | No<br>Yes | 1.65<br>1.70 | 2.88/84<br>3.20/-- | No<br>Yes (FEV1 below table value of 2.06 and FEV1/FVC equals 53%)<br><br>Dr. Worley noted airway obstruction, air trapping, and "no significant response" to bronchodilators. He diagnosed "severe obstructive airways disease—possible emphysema"; Dr. Worley noted a 35 pack year smoking history where the miner quit eight years ago; Claimant suffered "seizure-like activity" for three seconds during testing and the test was halted. |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Dx.* 15<br>12-04-03 | Odgers<br>63/70"<br>good/good | Yes | No | 1.69 | 3.59/72 | Yes (FEV1 below table value of 2.06 and FEV1/FVC equals 47%) |
| | | Yes | Yes | 2.10 | 4.15/90 | No<br><br>Dr. Odgers found that the test demonstrated a "moderate obstructive lung defect" with a significant bronchodilator response. By report dated January 15, 2004, Dr. Timothy Kennedy validated the test. *Dx.* 16. Dr. Kennedy commented that the miner "[a]ppears to have some degree of restrictive airways disease (not cwp)." |
| *Dx.* 43<br>04-27-04 | Repsher<br>63/68"<br>good/good | Yes | No | 1.79 | 3.44/67 | Yes (FEV1 below table value of 2.01 and FEV1/FVC equals 52%) |
| | | Yes | Yes | 2.10 | 3.67/86 | No |

Based upon the foregoing, the miner has not established total disability pursuant to § 718.204(b)(1) of the regulations. Initially, it is noted that Dr. Worley's test results after use of a bronchodilator are less probative because he notes that the test had to be halted prematurely due to difficulties experienced by Claimant. Indeed, Dr. Renn stated that this test was conducted during the miner's hospitalization for congestive heart failure and pneumonitis such that the study did not "represent (Claimant's) true baseline . .." However, the ventilatory testing of Drs. Odgers and Repsher consistently produced qualifying results prior to use of a bronchodilator, but they were non-qualifying after use of a bronchodilator. This testing reveals that the miner's ventilatory impairment is reversible to the extent that it becomes non-qualifying under the regulations. As a result, the ventilatory testing does not support a finding of total disability.

Total disability may also be established by qualifying blood gas studies under 20 C.F.R.

§ 718.204(b)(2) (2004). In order to be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found at the table at Appendix C. The following blood gas studies are in the record:

| ***Exhibit/ Date of Test*** | ***Physician*** | ***Altitude (feet)*** | ***Resting (R) Exercise (E)*** | ***PCO2*** | ***PO2*** | ***Qualifies?*** |
|---|---|---|---|---|---|---|
| *Ex.* 7 July 29, 1996 | Novick (Wyoming Medical Center) | 0-2,999 | R | 33 | 56 | Yes |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 36 | 319 | No |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 40 | 399 | No |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 34 | 346 | No |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 29 | 310 | No |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 36 | 164 | No |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 41 | 99 | No |
| *Ex.* 5 July 2, 1999 | Saint Francis Hospital | 0-2,999 | R | 39 | 65 | No |
| *Ex.* 5 July 3, 1999 | Saint Francis Hospital | 0-2,999 | R | 39 | 86 | No |
| *Ex.* 5 July 3, 1999 | Saint Francis Hospital | 0-2,999 | R | 52 | 55 | Yes |
| *Ex.* 5 July 3, 1999 | Saint Francis Hospital | 0-2,999 | R | 44 | 65 | No |
| *Ex.* 5 July 4, 1999 | Saint Francis Hospital | 0-2,999 | R | 37 | 116 | No |
| *Ex.* 5 July 4, 1999 | Saint Francis Hospital | 0-2,999 | R | 42 | 87 | No |
| *Ex.* 5 July 5, 1999 | Saint Francis Hospital | 0-2,999 | R | 42 | 82 | No |
| *Ex.* 5 July 5, 1999 | Saint Francis Hospital | 0-2,999 | R | 43 | 87 | No |
| *Ex.* 5 July 5, 1999 | Saint Francis Hospital | 0-2,999 | R | 44 | 66 | No |
| *Ex.* 5 July 6, 1999 | Saint Francis Hospital | 0-2,999 | R | 42 | 60 | No |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Ex.* 5<br>July 6, 1999 | Saint Francis Hospital | 0-2,999 | R | 41 | 95 | No |
| *Ex.* 5<br>July 7, 1999 | Saint Francis Hospital | 0-2,999 | R | 44 | 74 | No |
| *Ex.* 5<br>July 8, 1999 | Saint Francis Hospital | 0-2,999 | R | 39 | 81 | No |
| *Ex.* 5<br>July 9, 1999 | Saint Francis Hospital | 0-2,999 | R | 37 | 93 | No |
| *Ex.* 5<br>July 9, 1999 | Saint Francis Hospital | 0-2,999 | R | 29 | 157 | No |
| *Ex.* 5<br>July 10, 1999 | Saint Francis Hospital | 0-2,999 | R | 34 | 88 | No |
| *Ex.* 5<br>July 11, 1999 | Saint Francis Hospital | 0-2,999 | R | 29 | 96 | No |
| *Ex.* 5<br>July 11, 1999 | Saint Francis Hospital | 0-2,999 | R | 31 | 73 | No |
| *Ex.* 5<br>July 12, 1999 | Saint Francis Hospital | 0-2,999 | R | 31 | 113 | No |
| *Ex.* 10<br>Feb. 10, 2001 | McAlester Regional Health Center (room air) | 0-2,999 | R | 40.7 | 38.7 | Yes |
| *Ex.* 9<br>Feb. 10, 2001 | McAlester Regional Hospital (room air) | 0-2,999 | R | 40.7 | 38.7 | Yes |
| *Ex.* 9<br>Feb. 11, 2001 | McAlester Regional Hospital (room air) | 0-2,999 | R | 37.6 | 35.5 | Yes |
| *Ex.* 9<br>Feb. 15. 2001 | McAlester Regional Hospital (on oxygen) | 0-2,999 | R | 42.7 | 63.2 | No |
| *Ex.* 9<br>Feb. 16, 2001 | McAlester Regional Hospital (on oxygen) | 0-2,999 | R | 39.6 | 67.1 | No |
| *Ex.* 9<br>Feb. 18, 2001 | McAlester Regional Hospital (on oxygen) | 0-2,999 | R | 39.9 | 63.9 | No |
| *Ex.* 10<br>August 9, 2001 | McAlester Regional Hospital (room air) | 0-2,999 | R | 38.7 | 63.6 | No |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Ex.* 10<br>Jan. 10, 2002 | McAlester Regional Medical Center<br>(room air) | 0-2,999 | R<br>E | 39.2<br>32.2 | 50.1<br>52.7 | Yes<br>Yes |
| *Ex.* 10<br>Jan. 6, 2003 | McAlester Regional Medical Center<br>(on oxygen) | 0-2,999 | R | 47.8 | 75.4 | No |
| *Dx.* 14[3]<br>Dec. 4, 2003 | Odgers | 0-2,999 | R<br>E | 42<br>44 | 63<br>56 | No<br>Yes |
| *Dx.* 43<br>April 27, 2004 | Repsher | 0-2,999 | R | 39.0 | 64.0 | No |

Based upon the foregoing, the miner has demonstrated total disability pursuant to § 718.204(b)(2) (2004) of the regulations. Initially, it is determined that the variable results obtained during Claimant's various hospitalizations are not probative. As previously noted, these hospitalizations were for acute respiratory, and/or chronic cardiac, conditions that reasonably would have affected the results. However, the most recent tests of record, conducted by Drs. Odgers and Repsher, are highly probative. Notably, both tests yielded non-qualifying values at rest and Dr. Odgers' test produced qualifying values after exercise. Given the moderate level of manual labor required of Claimant in his last coal mining job, the fact that he is not able to adequately oxygenate blood on exercise would render him totally disabled. Dr. Odgers' study, which was validated by Dr. Kennedy, is persuasive that Claimant has a total disability and thus Claimant has sustained his burden under § 718.204(b)(2)(ii) of the regulations.

Finally, Claimant may establish total disability through medical opinion evidence wherein a physician has exercised reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment or comparable employment. 20 C.F.R. § 718.204(b)(4) (2004).

Initially, Claimant has the burden of establishing the exertional requirements of his usual coal mine employment. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). Once a claimant establishes that he is unable to perform his usual coal mine employment, a *prima facie* case for total disability exists and the burden shifts to the party opposing entitlement to prove that the claimant is able to perform comparable and gainful work. *Taylor v. Evans and Grambrel Co.*, 12 B.L.R. 1-83, 1-87 (1988).

In a statement prepared for the Department of Labor, Claimant stated that he last worked as a shift foreman from 1992 to 1998. *Dx.* 4. His job required sitting for two hours per day, standing for 8 hours per day, lifting 20 pounds 30 times per day, lifting 15 pounds 20 times per day, and carrying 20 pounds for 30 feet 30 times per day. Claimant's last coal mining job required sustained moderate manual labor.

[3] By report dated January 15, 2004, Dr. Timothy Kennedy concluded that the blood gas studies were valid. *Dx.* 16.

Based on this record, it is determined that Claimant performed a moderate level of manual labor. Comparing the exertional requirements of his last coal mining job with the physical limitations demonstrated on this record, it is determined that Claimant has established that he is totally disabled under 20 C.F.R. § 718.204(b)(4) (2004) through a preponderance of the medical opinion evidence of record. All of the physicians of record conclude that the miner suffers from a moderate to severe respiratory impairment. Claimant's treatment records demonstrate that he has been prescribed oxygen for use at home or work. Claimant testified that he uses oxygen every night for approximately 12 hours. Throughout his medical records, Claimant's dyspnea, shortness of breath, and hypoxemia on exertion have been recorded. It is evident that Claimant would not be able to perform the duties of his last coal mining job because of his documented respiratory ailments. However, as previously noted, the miner's respiratory ailments stemmed from his long-term history of tobacco abuse and cardiac disease. As a result, he is not entitled to benefits under the Act. Accordingly,

## ORDER

IT IS ORDERED that the claim for benefits filed by James Freeman is denied.

A
Thomas M. Burke
Associate Chief Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is:

**Benefits Review Board**
**U.S. Department of Labor**
**P.O. Box 37601**
**Washington, DC 20013-7601**

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207.

Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor,

Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).